DOCUMENT RESUME

ED 470 724 CG 032 071

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| AUTHOR | Scaturo, Douglas J. |
| TITLE | Clinical Dilemmas in Marital and Family Therapy: Art, Science, and Wisdom. |
| PUB DATE | 2002-08-23 |
| NOTE | 37p.; Paper presented at the Annual Meeting of the American Psychological Association (110th, Chicago, IL, August 22-25, 2002). |
| PUB TYPE | Information Analyses (070) -- Speeches/Meeting Papers (150) |
| EDRS PRICE | EDRS Price MF01/PC02 Plus Postage. |
| DESCRIPTORS | Counseling Theories; *Counselor Client Relationship; *Counselor Role; *Family Counseling; *Marriage Counseling; *Theory Practice Relationship |

ABSTRACT

Expanding the treatment system from the individual to the couple or family carries with it some unique challenges and fundamental clinical dilemmas for the marital and family therapist. Marital and couple therapy is explored with a focus on the dilemmas that dyadic relationships bring to the treatment context. The couple's "central relationship dynamic" is discussed as a way of distilling the sources of disharmony in an intimate relationship to the emotional concerns most relevant to treatment. The dilemma of therapeutic technique that is omnipresent in all forms of couple therapy is the distribution of the therapist's confrontation and support among the partners. This issue is elucidated in light of the role that the therapist occupies within the family and treatment hierarchies. Finally, the dilemmas involving the balance of relational power in the couple, the attribution of responsibility and blame, the question of family loyalties, and the balance of therapeutic "art" in an age of "science" and empirically validated treatments are also examined. (Contains 80 references.) (Author/GCP)

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ED 470 724

# Clinical Dilemmas in Marital and Family Therapy:

# Art, Science, and Wisdom

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by

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**Abstract**

Expanding the treatment system from the individual to the couple or family carries with it some unique challenges and fundamental clinical dilemmas for the marital and family therapist. Marital and couple therapy is explored with a focus on the dilemmas that dyadic relationships bring to the treatment context. The couple's "central relationship dynamic" is discussed as a way of distilling the sources of disharmony in an intimate relationship to the emotional concerns most relevant to treatment. The dilemma of therapeutic technique that is omnipresent in all forms of couple therapy is the distribution of the therapist's confrontation and support among the partners. This issue is elucidated in light of the role that the therapist occupies within the family and treatment hierarchies. Finally, the dilemmas involving the balance of relational power in the couple, the attribution of responsibility and blame, the question of family loyalties, and the balance of therapeutic "art" in an age of "science" and empirically validated treatments are also examined.

# Clinical Dilemmas in Marital and Family Therapy: Art, Science, and Wisdom

At its heart, the process of marital and family therapy comprises a series of clinical choices and recurring sets of dilemmas for the practicing clinician. A dilemma is typically seen as a situation involving a choice between two, less than satisfactory, alternatives. By its very nature, a dilemma evokes some degree of anxiety. In a clinical context, a treatment dilemma involves a choice or conflict that creates anxiety in the clinician about what to do or what to say next in the interview. The process of psychotherapy might well be regarded as the management of ongoing dilemmas, both for the patient and for the therapist. Thus, "dilemma management" (Scaturo & McPeak, 1998) is endemic to the psychotherapeutic process and the clinical situation.

## The Dilemmas of Dyads

Expanding the treatment system from that of the individual patient to that of the couple or family system carries with it unique challenges and fundamental dilemmas for the marital and family therapist. E. F. Wachtel (1979) has outlined various dilemmas from the standpoint of the individually trained psychotherapist who may be attempting to incorporate a family systems perspective into his or her clinical practice. The early pioneers in the field of family therapy likewise recognized the problem of the inherent complexity in this protracted form of treatment (e.g., Haley, 1963; Napier & Whitaker, 1973). The intricacy of marital and family treatment has caused both research (e.g., Alexander, Holtzworth-Munroe, & Jameson, 1994) and clinical conceptualization (e.g., Budman & Gurman, 1988) to restrict itself to either one (e.g., marital therapy) or the other (e.g., family therapy) of the two domains. The present discussion of clinical

dilemmas in systemic therapy will be restricted largely to those conflicts posed to the clinician in marital/couple relationship therapy or, what might be called, "dyadic dilemmas." Such dilemmas often focus around questions of balance in what has been termed the "central relationship dynamic" (Budman & Gurman, 1988) within the couple's relationship system.

**The Central Relationship Dynamic:**

**The Therapeutic Focus in Marital and Couple Therapy**

The notion of a *therapeutic focus* is a ubiquitous concept in all forms of psychotherapy, and most significant in short-term and time-limited forms of intervention. The therapeutic focus is an attempt to narrow and define a given psychotherapeutic problem for a given episode of time-limited treatment. In brief psychodynamically-oriented individual therapy, the concept of a *dynamic focus* (e.g., Schacht, Binder, & Strupp, 1984) is a well-documented clinical phenomenon. Furthermore, the concept of the psychodynamic focus appears in the literature under a wide array of synonyms (Scaturo, 2002b). In each instance, though, the focus is seen as the nucleus of the individual's problem, encompassing the cardinal symptom, presenting problem, related intrapsychic conflict, interpersonal dilemma, and maladaptive coping pattern. The psychodynamic focus is characterized by a "functional salience" in which the patient's presenting complaint and maladaptive interpersonal behavior pattern are integrally related to the emotional or interpersonal difficulty that the patient is trying to solve.

Likewise, in assessing couples and families for treatment, it is helpful to distinguish between dimensions that may *common* to both families and couples and those that are *specific* to the couple's relationship (Budman & Gurman, 1988). With regard to

the couple's dyadic relationship in particular, Budman and Gurman (1988) note that the aspects of assessment for treatment should include (a) the marital relationship's history, (b) the specific nature of the marriage contract or understanding that the couple have with one another, (c) the couple's sexuality and sexual functioning, (d) the current level of commitment that each have in the marriage, and (e) the presence/absence of any substance or spouse abuse. Of the factors embedded in the couple's relationship history, the single most important aspect of marital assessment and the most useful in establishing a focus for treatment is the couple's *central relationship dynamic* (Budman & Gurman, 1988). This dynamic incorporates the recurring conflict and source of disharmony that has transpired for the couple over the development of their relationship. Like the concept of the psychodynamic focus in individually-oriented treatment, the central relationship dynamic in systems-oriented treatment has been characterized by a variety of terms in the field with an essentially similar meaning. Aspects of the concept have been encompassed by the terms "interlocking pathology" (Ackerman, 1958), "family homeostasis" (Jackson, 1957), the "marital quid pro quo" (Jackson, 1965), the "overadequate versus inadequate relationship" (Bowen, 1960), the "one-up/one-down relationship" (Haley, 1963), "complementarity" (Bateson, 1935, 1972; Simon, Stierlin, & Wynne, 1985), as well as the concept of "codependency" (Scaturo, 2002c; Scaturo, Hayes, Sagula, & Walter, 2000).

The dilemmas involved in maintaining an *ongoing balance* in a well functioning intimate relationship stems in part from the common clinical observation that "people choose spouses who have identical levels of immaturity but who have opposite defense mechanisms" (Goldenberg & Goldenberg, 1980, p. 98). While individuals in the couple

may be matched for their level of psychosocial maturity, or level of *differentiation* from their families of origin (Bowen, 1985), the individuals select one another based upon their opposite methods of coping with life. From an object relations theoretical perspective (e.g., Scharff & Scharff, 1991), this selection occurs in an adaptive effort to regain parts of one's self that were abandoned by the child in choosing a coping style early on in life. By choosing a spouse who has those traits left behind, one has the ability, through the couple's relationship, to approximate a more whole sense of self and ability in managing the world.

For example, the husband with obsessive-compulsive tendencies may marry a somewhat histrionic wife is likely to have been initially attracted to her "fun-loving" ability in life – something that he may have largely abandoned a long time ago in his childhood. Ten years later, in the marital therapist's office, appreciation of her fun-loving nature may have been supplanted by a suspicion and distrust in her over her "overly flirtatious behavior" at parties. In like fashion, this histrionic woman may have been initially attracted to her obsessive-compulsive husband's "strength and ability for organization" – something which she may have given up a long time ago in her family of origin. Now, her perception of her husband's talent for organization and strength has been replaced by the critical descriptors of him as "overbearing and stuffy." To further augment their difficulties, their mutual abilities to tolerate and respond to these criticisms have been curtailed by their increased feelings of insecurity that their spouse may be no longer be emotionally attached as they once were as evidenced by their no longer valuing what they once did.

Such relational dynamics have important implications for the initial interview of marital therapy. The couple's presenting complaint is usually quite telling. Often, the presenting complaint that each spouse has of the other is *precisely* those qualities that, at an earlier time in modified form, were those that attracted them to one another in the first place. It is for this reason that a critical question in marital assessment is: "What qualities first attractive in your spouse?" This inquiry enables the couple in conflict focus on something positive about their spouse while at the same time shedding light on the central relationship dynamic. In the black comedy film based upon the novel, *The War of the Roses* (Adler, 1981), the actor Danny DeVito plays a divorce attorney who is giving rather expensive "$450 per hour advice" to a man contemplating divorce. He tells the man of the horrific story of a couple, Oliver and Barbara Rose, who descend into hatred and mutual cruelty of one another through a divorce proceeding that ultimately brings about their demise. After relating this story to the young man, Devito's character offers him the following choice: to either prepare himself for the very worst because *"a civilized divorce is a contradiction in terms"*...or...*"get up and go home and try to discover some shred of what you once loved about the sweetheart of your youth."* For those who choose to do so, this is where couple therapy begins.

The sources of disharmony in an intimate relationship can be often characterized by only a relatively few major issues (Gurman, 1981). These are typically interrelated to changes and alterations that take place in a previously comfortable central dynamic in the relationship as exemplified above. Most of the couple's dilemmas tend to be organized around this essential "marital bargain" or "quid pro quo" (Jackson, 1965), whether this exchange is conscious and verbalized, conscious but not verbalized, or mostly

unconscious (Sager, 1981). Regardless of whether the dilemmas into which the couple draws the therapist appear to be about power and money, sex and affection, responsibility and blame, divided loyalties between their respective families of origin, or simply the apportionment of the therapist's degrees of confrontation and support, these dilemmas and conflicts tend to be symbolically related to their central relationship dynamic. Given this backdrop, the following discussion outlines some of the more frequent and consequential dilemmas experienced by the therapist in contemporary marital and couple therapy.

## Confrontation and Support:

## The Dilemma in Therapeutic Technique in Systems-Oriented Treatment

A ubiquitous dilemma in therapeutic technique in almost all forms of psychotherapy involves the degree to which the therapist supports and validates a given side of a patient's personal conflict versus the degree to which the therapist challenges or confronts a given aspect of the patient's point of view (Scaturo, 2002b). Verbal expressions of understanding and empathy tend to provide emotional support for the patient, while questioning the patient's perspective and inquiries for clarification tend to confront the patient's viewpoint and urge him or her to reexamine and reevaluate his or her thinking about a given issue. Metaphorically speaking, confrontation is the "surgical incision" in therapy, while the therapist's emotional support provides the "anesthetic" for any given intervention (Scaturo & McPeak, 1998). Confrontational intervention can take a number of forms, including the "interpretations" about a patient's or family's behavior within a psychodynamic approach to therapy (e.g., Scaturo, 2002b), psychoeducational interventions (e.g., teaching assertiveness skills) within a cognitive-behavioral framework

(e.g., Scaturo, 2002d), or the assignment of directives or tasks as is done in a problem-solving or strategic family therapy approach to treatment (e.g., Haley, 1976; Madanes, 1981). Each of these more directive approaches "borrows" on the strength and quality of the therapeutic alliance that the therapist has with each and every patient or family member in treatment (e.g., Safran, 1993; Scaturo & McPeak, 1998). As a result, when confrontation takes the form of a homework assignment or directive that is given to a particular family in treatment, it is essential that the task given to the family equitably include an aspect for each and every family member so as to reasonably distribute the "request" (often seen by the family as a "demand") being made by the therapist.

Thus, in marital and couple therapy, the difficulty in balancing the confrontational and supportive aspects of psychotherapeutic technique is compounded by the need to not only decide when support versus confrontation is needed *within* a given individual, and in what degrees, but also to decide how and when to distribute degrees of support versus confrontation *among* each member of a couple, each of which may be in conflict with one another at any given point in time. Support of one spouse's position against another's forms what can be, at most, a *temporary* alliance with the supported member of the couple that can be tolerated by the other spouse for only a limited period of time without alienating him or her and appearing to form a more permanent coalition with one spouse against the other (Minuchin, 1974). As a result, the couple therapist may frequently feel as though he or she is constantly "robbing Peter to pay Paul" as he or she attempts to balance emotional support and the therapeutic alliance in the couple therapy session (Scaturo & McPeak, 1998). The couple therapist frequently finds him or herself allying with the person whom may be taking the more reasonable or more conciliatory stance at a

given point in time, only to find his or her support shifting a few moments later as the rationality of the moment wavers or evaporates. Recognizing when one member of the couple is "extending an olive branch of peace" and capitalizing on the reinforcement of this is a particular skill of an adept systems-oriented therapist. The alternation of support and challenge of the systems therapist becomes part and parcel of the systemic interaction of the couple as a family unit.

***The Family Hierarchy.*** To more fully appreciate the significance of such therapeutic maneuvers in couple therapy, this issue must be viewed in light of the hierarchy that exists in the family and in the therapy session. The notion of a hierarchy in family treatment outlines the power structure, role functions, and generational boundaries of the various sub-systems within the family (Simon, Stierlin, & Wynne, 1985). Along generational lines, the parents hold more power and decision authority than do children in a functional family system. Role reversal and incongruity in this area may result, for example, in the "parentification" of a child (e.g., Haley, 1976), that is a sign of pathological family functioning that robs children of their childhood and deprives parents of their responsibility and authority within the family. When such incongruities exist in a family in treatment, the family therapist generally works to put the parents back "in the driver's seat" (Minuchin, 1974). An example of parentified behavior in an oldest daughter, age 10, of three siblings, who secures the house at night because her alcoholic parents are frequently too intoxicated to do so themselves. In addition to the treatment of the parents' alcoholism, a family therapist, in this instance, might directly assign the parents the task of locking up the house each evening in an effort to restore their adult roles and functionality within the family hierarchy. Just as the power distribution and

clear role function definition in the family hierarchy between the generational sub-systems is a sign of healthy *family* functioning, recognition of the co-equal status of the partners within the *couple* sub-system is likewise a designation of relational emotional health in the couple (Scaturo, 1994). While the role functions of husband and wife may vary, the importance of *equal value* for these respective functions needs to be recognized by each member of the couple in order for this sub-system to thrive. For couples in conflict, however, truly valuing their partner's contribution to the family system can be easily lost in the heat of the moment.

***The Treatment Hierarchy.*** For couples and families in therapy, superimposed on top of the couple and family hierarchical structure is the added feature of the *treatment hierarchy*. The marital and family therapist temporarily becomes a part of a given family's hierarchy with the children's generational sub-system on the bottom level, the couple's sub-system in the middle, and the therapist or co-therapist's occupying the upper level of the hierarchy. Recognition of the therapists' place within the treatment hierarchy is critical, because it serves to explain why a couple in conflict may vie for the therapists' support and approval in the same way that siblings within the children's sub-system vie for the approval of their parents in the next highest generational level in the family hierarchy. To gain the support and approval of someone at a higher status level in a given system is, therefore, to gain power in the conflict. When such power is obtained on an ongoing basis, a destructive coalition is formed. This is why, when a child "acts out" against or disrespects one of the parents in a family, it is frequently said that they are able to do so, because he or she "has friends in high places" (i.e., a coalition across generational lines with one of the parents against the other). The criticality of the balance

of power within a couple's sub-system is also why the astute therapist will delicately balance and apportion his or her emotional support between the members of a couple. In doing co-therapy, especially when there is bi-gender co-therapy team that is often used in training settings, it is crucial that the co-therapists work out a respectful and co-equal relationship with regarding to intervening with the couple or family (Framo, 1982a). The modeling of equity within the couple sub-system is an important function of the co-therapy team and particularly significant in couple therapy.

One other point is relevant to the notion of the treatment hierarchy. For strategic therapists who are working within a "reflecting team model" (e.g., Andersen, 1987, 1991, 1992, 1993; Papp, 1980) behind a one-way observation mirror, it is significant to note that the reflecting team occupies the *highest level* within the treatment hierarchy even above that of the therapists themselves. The clinical rationale for this model stemmed from the realization that a new system and hierarchy are created between the therapist and couple and/or family. The therapist, working directly with the family, may have periodic difficulty in maintaining an objective view of the treatment system of which he or she is a part (Simon, Stierlin, & Wynne, 1985). It is in part the increased objectivity of the reflecting team, as well as the mystique of the team fostered by their anonymity behind the one-way mirror, that allows them to occupy the highest level in the treatment hierarchy with the couple or family and lends power to their periodic interventions by telephone or intercom to the therapist(s). While consideration of this approach extends the notion of the treatment hierarchy and adds to the richness of this issue, such a treatment model, like the notion of co-therapy itself, has been increasingly restricted to

training settings because the availability of multiple therapists for a single clinical hour has become cost-prohibitive in an age of managed healthcare.

Perhaps a dissenting view of the hierarchy in treatment can be found in the more recent work of the *narrative family therapists* (e.g., Epston & White, 1992; White & Epston, 1990). While traditional family therapists have historically given families directives for change (e.g., Haley, 1976), narrative family therapists primarily ask questions of their families in treatment. The treatment techniques in their clinical armamentarium include the use of questions to explore the exceptions to the family's problems and the significance of these variations, the raising of dilemmas to examine the possible aspects of a problem before those dimensions take place, and the use of letter writing to serve as medium to continue the dialogue between the family and therapist between therapy session (Gladding, 2002). The narrative therapists' encouragement to take a collaborative listening position with the family and to ask questions that take a non-imposing approach with the family place them at variance with some of the above-noted observations of the therapist in the treatment hierarchy. Narrative therapists point to their use of questions rather than interpretations or directives as evidence to their co-collaborative, non-impositional, and non-hierarchical stance in treatment. However, critics of this approach note that as much as the narrative family therapists wish to view themselves an non-manipulative in their questions, they are indeed more directive than they claim to be. Nichols and Schwartz (1998, p. 417) note that, "Regardless of how many questions they use, they *are* looking for a certain class of answers and, consequently, are leading clients to particular conclusions" [italics original]. Thus, the notion of hierarchy within the family in treatment, and the therapist's place within it, has

saliency, whether or not one chooses to emphasize it within any given theoretical framework.

**The Balance of Power**

According to strategic family therapists, "all couples struggle with the issue of sharing power and of organizing in a hierarchy where areas of control and responsibility are divided between the spouses" (Madanes, 1981, p. 29). Power in a relationship can take many forms, and is a dynamic force which changes constantly over the life cycle in the couple's relationship predicated upon a myriad of life factors that can affect the relative status of each spouse/partner at any given point in time. Thus, for a couple's relationship to function adaptively, the question of relational power is always a question of balance. More specifically, the term "power" frequently implies "decision power" over a given domain of life. The various arenas for decision power can include housework versus income-producing activity, the emotional areas of life versus the intellectual side of life, and activities surrounding children and extended family versus social engagements with friends. Ultimately, it is incumbent upon a couple to arrive at a mutually satisfactory arrangement regarding the division of power. Otherwise, it is then that emotionally symptomatic behavior can develop as a coercive means of re-balancing or redistributing power that has been unjustly dominated by one or the other parties. In a minor form, one might consider the example of a spouse who develops a tension headache that exempts him or her from a social engagement with a certain group of friends that hasn't been properly negotiated and agreed upon by the couple in the first place. More serious is the repetitive failure to negotiate equitable "say-so" in this area that results in *chronic* headaches on the part of one or the other spouse. In more linear

terms, one might describe this as "passive-aggressive behavior." From a systemic perspective, though, this is passive-aggressive behavior on the part of *both* spouses, not only the "symptomatic" party.

One of the more significant determinants of power and conflict in the couples' relationship is that of income-producing activity: Who earns the income? Who earns *more* of the income? What are the ramifications of this upon the relationship? Carter believes that the old adage, "he who has the gold, makes the rules," is equally applicable to the establishment of power in an intimate relationship as it was for the business relationship to which the saying was originally applied, translating the original version to "whoever controls the purse strings, controls the relationship" (Carter & Peters, 1996). Also, the use of the pronoun, *he*, in the original adage, is likewise applicable to the relational version, given the continued disparity between the higher incomes of men versus the, most often, lower incomes of women, even in the current millennium. That money should be deemed so important is not particularly surprising from the standpoint of a hierarchy of motivational needs (e.g., Maslow, 1970). With physiological needs at the base of that hierarchy, and with the survival-related needs of air, water, food, sleep, and sex ordered within that foundational level, it is clearly understood that "money puts food on the table" and is our "bread and butter" concern. Given that lower needs must be satisfied before higher needs can be addressed by the individual, it is an undisputable position that income precedes subsequent needs for safety, love, and esteem. Thus, money and the need for it strikes us at a level of necessity for survival that lends power to one who is able to provide for it.

The need for safety is, however, the very next rung of the conceptual ladder. Stability and constancy are necessities in a chaotic world. While these needs are more psychological than physiological, the security of a home and the safety of a family clearly are co-requisites for *maintaining* stable income-producing activity for any sustained length of time. Ultimately, the order of some safe living space and attending to the relatively mundane domestic tasks that provide this "base of operations," are shared by all human beings and have tremendous functional value. Most unattached individuals, particularly single parents, will comment freely on the Herculean effort that is required to accomplish both alone (unless independently wealthy) in the complexity of today's world. The criticality of a partner who is able to equitably shoulder the "slings and arrows" of *both* the occupational and domestic worlds cannot be overstated. Findings from the Harvard landmark longitudinal study of adult development across the life span have shown that the best predictor of good health and aging well is a secure marriage (Vaillant, 2002). Vaillant (2002) concludes from the data that, marriage is not only important to a healthy aging process, it is also a *cornerstone of resilience* in adulthood and late-life.

According to Bowlby (1988, p. 121), "although food and sex sometimes play important roles in attachment relationships, the relationship exists in its own right and has a key survival function of its own, namely, protection." Thus, Bowlby argues for what he calls the "primacy of intimate emotional bonds." Given such primacy, a view that is shared herein, it seems that ultimately the *value* of that relationship, and what it provides *in its own right,* must be recognized by the couple regardless of whose activities earns the "lion's share" of the jointly deserved assets. Ultimately, Carter and Peters (1996) offer

some guarded agreement on this point. While they draw a distinction between what they consider to be financially "equal" arrangements and the term "equitable" for which they feel "male therapists" hold a particular penchant, noting that "equitable" means "fair," they concede that equitable relationships (e.g., husband makes more money while wife does more child care) can indeed be functional. They offer the qualification that such functionality seems *only* possible if each member of the couple holds to the "personal belief that earning money and homemaking are *equally important* contributions of equal partners who share important decision making and have equal access to the money" (Carter & Peters, 1996, p. 82). It is particularly critical that the couple therapist advances such a belief, particularly since is almost always be variation in income and corresponding variation in domestic responsibilities. The therapeutic task is for the therapist to help the couple in excavating what is truly functional for that particular couple.

In actual clinical practice, a frequent source of conflict brought in by couples, particularly couples in families with young children, is the question of devising an "equitable division of family labor." In this instance, "family labor" means the *total* amount of man-hours (or, person-hours) that a required by a family to maintain their lives, both income-producing *and* home-upkeep (i.e., domestic tasks and child-care responsibilities). Families with young children are particularly vulnerable to this issue, because they must undergo a rather massive developmental adjustment from "an intimate game of two" (Haley, 1973) to accommodating new entries and task demands into the family system that they had worked out previously. The addition of children into the equation increases the home-related labor enormously in a myriad of unanticipated ways.

Recognizing the need for an equitable division of the *collective* work hours. Thus, it is not sufficient for the primary income-producing party in the family to simply take the stance that: "I worked today. I've done my job." -- when four more "person-hours" of domestic work and childcare still exist at home even at the end of the work day. The noted social consciousness-raising saying is as applicable to family life as it is to society: "If you want peace, work for justice."

**The Attribution of Responsibility and Blame**

The "upside" to the question of who has responsibility is having decision-making power and authority. The "downside" of personal responsibility concerns the question of blame for unfortunate decisions and courses of action. Politicians are particularly adept at taking credit for the upside, while evading blame for the downside. There are "politics of family life" (Framo, 1982c), as well. In reality, however, one cannot have it both ways. According to E. F. Wachtel (1979), the most significant psychotherapeutic dilemma from a family systems viewpoint concerns this question of "*Who is to Blame?*" Within this framework, the responsibility for marital conflict is not seen as residing exclusively within any one individual, although the respective partners in a couple frequently enter treatment believing that this is the case. As a result, when a couple is in conflict, the question posed to the therapist by each partner tends to be some variant of *"Is it Me or My Spouse?"* who is to blame for the problem (Scaturo & McPeak, 1998). The clinician typically regards this as a question of internalization versus externalization of responsibility. With conflictual couples, both tend to present at treatment's outset with a fairly high degree of externalization, each seeing their spouse's faults with utter clarity

and insight while tending to minimize or overlook their own contributory behavior to the problem.

Classic social psychological research (e.g., Heider, 1958; Oskamp, 1991) has distinguished between internal versus external attributions for interpersonal behavior and actions. An *internal attribution* is one in which a person concludes that the cause for a particular person's behavior (in this instance, his or her spouse) is due to some personal character trait, such as laziness or inconsiderateness. In contrast, an *external attribution* is one in which a person might conclude that the causes for a given person's behavior is due to some situational factor outside of the person's control, such as time pressures or a heavy workload. Interestingly, an important concept in this area of study has been the finding of *actor-observer biases* in making internal versus external attributions (e.g., Jones & Nisbett, 1971; Storms, 1973). An observer of someone else's behavior (e.g., his or her spouse's) is likely to attribute the reason for it to internal characteristics. For example, a spouse might conclude that, *"My spouse did not make it home in time for dinner with me, because he [or she] is basically an inconsiderate and thoughtless person."* By contrast, however, an actor performing that same behavior frequently attributes its cause to any apparent situational pressure. By way of contrasting example, this same spouse might conclude that, *"I did not make it home in time for dinner with my spouse, because I was overwhelmingly busy at work."* These social psychological observations have significant import for understanding and negotiating marital conflict.

While such attributional behavior may be commonplace in interpersonal contexts, it becomes particularly toxic in an intimate relationship. According to Gottman (1994, 1996, 1999), *"The Four Horsemen of the Apocalypse"* in marital demise are, first, the

spouses' mutual and unrelenting *criticism* of one another, then the development of mutual *contempt* of one another, followed by mutual *defensiveness* in their behavior, and finally the *stonewalling* of any feedback or input from the spouse. The type of attribution that takes place in actor-observer biases is essentially the first horseman of the marital apocalypse. In this regard, it is important to note that "complaints" of one's spouse are not the same as "criticism." Complaints are normative in marriage and address specific behaviors or actions. An example of a complaint might be, *"Why didn't you clean up around the house?"* By contrast, criticisms throw in blame and general character assassination of internal attributions by an observing spouse. A contrasting example of criticism might be, *"Why didn't you clean up around the house. What's wrong with you, anyway? Why are you so lazy?"*

As a result, in the beginning phase of marital therapy, it is often helpful to pose the following question to each member of the couple (Scaturo & McPeak, 1998, p.4): "What do you think *you* could or should do to help alleviate some of the difficulty and improve your marital situation?" Such a question, which directs each member of the couple to look inwardly toward their own, contributing problematic behavior, is invariably helpful in a clinical context fraught with externalizations. It is an attempt to move the couple *from* the externalization of blame *to* the internalization of responsibility for what is essentially a co-owned problem. For the purpose of assessment, it is helpful to know whether or not a particular couple has the psychosocial maturity and the mutual ego strength to entertain such a question. For purpose of intervention, it serves to help the couple shift their viewpoint of their marital difficulties to a more systemic perspective, which may serve to reduce the tendency toward mutual blaming.

Furthermore, if the couple is able to generate appropriate and reasonable responses to this intervention, then this may serve to point out some constructive avenues for therapeutic change.

**Balancing Family Loyalties**

Another topic that bears consideration when dealing with the question of blame is the therapeutic examination of the partners' respective families-of-origin contribution to the distress experienced by the couple. Framo (1993) has estimated that as much as 80% of the variance in marital discord may be related to unresolved emotional conflicts within the respective families of origin. In therapy, it may be important for each member of the couple to understand that much of how they treat each other is derived from what each has learned about intimate relationships from his or her family of origin. The patients' dilemma surrounding perceived blame might be characterized by the question, "*Is it my spouse or my parents?*" who is/are to blame for the problem (Scaturo & McPeak, 1998). Articulated elegantly by Framo (1982c, pp. 188-189): "The price for robbing of self during the growing years exacts a toll and leaves a legacy, giving rise to the ambivalence that all people feel about their close relationships. Since old scores have to be settled and reservoirs of hatred cannot be contained, someone has to pay. Those someones are usually the current intimates -- the mate and children; the demons of today are punished by the internal ghosts of yesteryear."

Assisting each member of the couple to see that the spouse is frequently a stand-in target for the anger and conflict often helps to alleviate some of the marital discord. A variation of this technique has been utilized frequently in individual psychotherapy to help lessen the self-blame that the patient may feel with an otherwise confrontational

interpretation of a particular maladaptive or self-defeating behavior pattern that the patient is addressing in therapy (Wachtel, 1979). For example, a given therapist might say, "Of course, your behavior is an understandable response, given the family environment in which you were being raised" (Scaturo & McPeak, 1998). At other times, the mode of treatment that can best deal with this issue is the "family-of-origin consultation," used as an adjunct to ongoing individual or couples treatment her (e.g., Framo, 1982c, 1992; Wachtel & Wachtel, 1986). A family-of-origin therapeutic consultation is predicated upon the assumption that working problems out directly, face-to-face, with the family of origin, rather than through a transferential relationship with a therapist, can have powerful curative effects (e.g., Bowen, 1985; Boszormenyi-Nagy & Spark 1973; Framo, 1982c; Whitaker, 1976). In this type of therapeutic approach, the patient would have the opportunity to discuss directly with the members of the original family group some of the historical concerns that have plagued him or her emotionally over the years. A central theme in this form of treatment is the aspect of forgiveness of the parents, which helps to heal such wounds for both the parents and children (Enright, 2000).

Most people are torn between confronting their families of origin, especially their parents, on their grievances from the past on the one hand, and avoiding confrontation on the other fueled by powerful feelings of loyalty to those who have raised them. This dilemma becomes even more complex and augmented when the *spouse* has grievances (mostly, present-day concerns) with his or her in-laws, often about various forms of intrusiveness upon the couple's life (e.g., how they spend their money, how they discipline their children). In these instances, the question of loyalty to one's parents

versus allegiance to one's spouse forms the crux of this dilemma, which is not easily navigated. Once again, this can be a particular problem in the stage of the family life cycle in which young couples who are recently married and raising young children. The life choices that the newly married couple makes are generally entangled in some way with the alliances that each have (or do not have) with their respective parents. For example, if one set of parents (or both) continue to provide some type of financial support for the new family, there is either an implicit or explicit expectation about how much "say-so" they have regarding various family matters, including aspects of how the grandchildren are to be raised (Haley, 1973). Couple must negotiate ways of having clear, but semi-permeable boundaries, with each of their families. Couples who attempt to resolve this conflict by some type of complete "emotional cut-off" (Bowen, 1985) from their respective families of origin generally not as successful as those who are able to achieve some independence while still remaining in emotional contact with their extended families. Marital therapists remain cognizant of Framo's (1982b, p. 126) axiom: "When you marry, you don't just marry a person; you marry a family."

**Balancing Art, Science, and Clinical Wisdom**

A final dilemma is one that marital and family therapists share with their other colleagues in the mental health professions of psychiatry, clinical psychology, and clinical social work. Since its early beginnings, the "art" in the practice of psychotherapy has been inextricably intertwined with the "science" of its study. Freud saw psychoanalysis as a research method for studying various elements of mental functioning as much as he saw it as an approach to the treatment of mental disorders (e.g., Gay, 1998). After the Second World War the field of clinical psychology adopted a "scientist-

practitioner model" for training that called for an equal emphasis upon scientific research and clinical practice (Raimy, 1950). This marriage of science and practice has recently celebrated its 50th anniversary (Benjamin & Baker, 2000). Within the last five years, however, the integration of science and practice has been reconceptualized and predicated upon the concept of the "local clinical scientist" (Peterson, Peterson, Abrams, & Stricker, 1997; Stricker & Trieweiler, 1995). In this conceptualization of training, it is no longer expected or required that the practicing clinician to have the research skills necessary to contribute to the general body of scientific knowledge in the field of psychology. Rather, this approach still expects competent clinicians to adopt a scientific attitude in their approach to clinical problems, an ability to apply available scientific knowledge to their work, and an empirical skepticism and hypothesis-testing attitude about practice that would typify that of a good scientist, as well. Likewise in the field of marital and family therapy, there has been a movement toward the use of evidenced based therapy in which the outcome of family systems theoretical and clinical approaches is scrutinized through the eyes of empirical testing.

The art-science dialectic in the field of marital and family systems therapy is well-illustrated in the exchange concerning the outcome and follow-up studies comparing behavioral marital therapy (BMT) with that of insight-oriented marital therapy (IOMT) (Alexander, Holtzworth-Munroe, and Jameson, 1994). In a study by Snyder and Wills (1989), for example, while there we no differences in outcome between the BMT and IOMT conditions at either termination of treatment or the 6-month follow-up, a significant difference in relapse rate was found in which 38% of the 26 BMT couples had divorced whereas only 3% of the 29 IOMT couples had terminated their marriages at the

time of a 4-year follow-up (Snyder, Wills, & Grady-Fletcher, 1991). In response, behaviorally-oriented marital therapists (Jacobson, 1991a, 1991b, 1991c) argued that the treatment presented in the IOMT condition was representative of more recent "clinically sensitive" versions of BMT (i.e., "new wave BMT") versus the more "rigidly structured, outdated BMT" (Alexander, et al., 1994, p. 604). In essence, the argument was that the IOMT was a mislabeling of 'new, improved' BMT, comparing it then to a more traditional, highly structured version of BMT (Jacobson, 1991a). Assuming that the premise of this argument is valid, it is nevertheless important to consider the *direction* of change for the newer version of BMT regardless of the label. It is important to consider just what "clinically sensitive" means (indeed, one would be hard pressed to envision a couple that would wish to engage in a therapy that was *not* clinically sensitive). What appears to constitute the "improvemcnt" in the IOMT condition over more traditional BMT, even from the behavioral marital therapists' point of view (e.g., Jacobson, 1991a; Markman, 1991), involves *less* rigidity and structure regardless of whether or not this could be regarded as insight-promoting *per se*. The components of empirically validated therapy must be the artfully blended by the individual clinician to adapt the therapy to the needs of a given couple, rather than expecting the couple to adapt to the rigid structure of behavioral components for the purposes of scientific rigor.

From a practical standpoint, the dilemma surrounding art versus science in all forms of psychotherapy is inextricably intertwined with the concept of manualization of treatment (Scaturo, 2001), and how rigidly one adheres to it. Ultimately, it may be more valuable to identify the critical components of treatment and understanding how and when to competently use them, rather than fostering rigid adherence of manualized

protocols (Chambless, 1996). But, what are some of the critical components of psychotherapy in general, as well as the critical components of marital and family therapy in particular? Cummings and Cummings (2000) outline "key ingredients" relevant to the art and essence of psychotherapy in general that cut across the particular modalities used: (1) an empathic atmosphere conduce to change; (2) realistic goals for behavior change; (3) a competent understanding of transference and countertransference; (4) an ability to address the patient's interpersonal/familial distortions; (5) an articulated understanding of the patient's conflict and ambivalence surrounding interpersonal closeness; and, finally, (6) some form of symptom reduction. Other authors have focused upon the "ubiquitous nonspecific factors in psychotherapy" (Scaturo, 2001, p. 526) that include such elusive human variables such as a confiding relationship, an emotional "presence," caring, compassion, and the arousal of hope (Strupp & Hadley, 1979). In training competent systems-oriented therapists, it may be particularly important to identify components that seem to transcend any particular theoretical framework and, thereby, seem to have demonstrated *transtheoretical* and *transmethodological* relevance. These aspects include the concept of the patient or family's readiness for therapy and the *stages of change* that they bring to the treatment context (e.g., Prochaska & DiClemente, 1992), the concept of fostering *self-efficacy* in the patient or family (e.g., Bandura, 1977, 1998), the quality and integrity of the *therapeutic alliance* (Safran, 1993), and the ability of the therapist to grapple with the *fundamental clinical dilemmas* (Scaturo, 2002a) inherent in a complex family treatment context. Ultimately, the integration of the *art* and *science* of therapy yields an amalgam of *clinical wisdom* (e.g., Karasu, 1992; Scaturo & McPeak, 1998), which continues to have relevance in this multifaceted area of intimate human relations.

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**Footnotes**

Portions of this article were a part of the presentation entitled, "Clinical Dilemmas in Marital and Family Therapy: Art, Science, and Wisdom," by Douglas J. Scaturo, Ph.D., to the Division of Family Psychology at the 110th Annual Convention of the American Psychological Association, Chicago, Illinois, August 23, 2002. Support for the preparation of this article was provided by the Medical Research Service of the Department of Veterans Affairs. The opinions expressed in this article are those of the author and do not necessarily reflect those of the Department of Veterans Affairs.

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